BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE EFFECT OF A MOTHER'S MENTAL ILLNESS UPON THE FAMILY UNIT AS SEEN FROM A STUDY OF A GROUP OF PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL.

A Thesis

Submitted by

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(A.B. Pembroke College, 1941)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1943

School of Social Work
Nov. 1, 1943
588

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INTRODUCTION

CHAPTER I

Anthropologists interested in family organizations of the different cultures have painstakingly studied them. It seems that one of the primary factors in a family organization is the economic structure of the specific culture. Thus they have noted in our own culture that the industrial-economic set-up has brought about the small immediate urban family to replace the agricultural-economic based rural family that was large and economically and socially self-sufficient. The urban family unit with which this study deals is the small one of father, mother, children (not many). The father is the breadwinner; the mother is the homemaker. The children unlike those in a rural family have a longer childhood and dependency period before they become economically self-sufficient.

This small family seems less able than the large rural family to stand the stresses and strains of life. The loss of one parent becomes much more of a blow than would have been the case in an economically self-supporting family. For instance in the depression many a breadwinner could not--through no fault of his own--live up to his role. He could not support his family. He could not turn to relatives. He had to accept government relief. He lost face as a breadwinner. For some this loss of status proved too much and they deserted their families thus breaking up the family unit. Most managed to keep going with the relief that was offered. Many family units

considerably shaken during the depression by such an economic blow somehow held on and maintained their unity.

A major factor in the continuance of the family as a unit was the mother's continuance in her role of homemaker with the aid of relief. The government, in an economic way, took over part of the father's role. What we are implying in the foregoing is that the father has an important role in the family unit but that it is a role that can be partly taken over by others without breaking up the family. In fact, the purpose behind Aid to Dependent Children is to prevent family break-up by keeping children with their mothers. They seem to feel a family is really broken when the children are taken away from the mother. Our culture does not provide a comparable compensation for the mother's role of homemaker as it does for the father's role as breadwinner.

The above describes how difficult it is to replace the mother in a home. Now when one considers the effect of mental illness upon the small family unit of our urban culture one knows that the loss of the father might be disorganizing but that the loss of the mother would probably be more disorganizing. The loss of a father, for any reason whatsoever, can be partially compensated for by giving of relief but not so the mother's. The loss of the mother would be evident by her removal from the home and by the removal of the children from the home by agencies, if the children are quite young.

Long before undertaking this study the writer became interested in the effect of a mother's mental illness upon the family unit from observation of several cases. The first case was observed five years ago as a volunteer worker in a family welfare society. The case concerned a mentally ill mother, her husband, and her seven children. The writer was struck by the break-up of the family unit with the mother being hospitalized and the children scattered about to the four winds, as it were. The two older children remained in a broken home with their father who was much upset; the five other children were distributed about in three different institutions for children. At present, five years later, the mother and all but one of the children have returned to the home; the family is somewhat reunited but the memory of the break-up is still fresh and hardly forgotten by any of the members of the family. The writer moved by this effect of a mother's mental illness and hospitalization upon a family unit wondered if anything could be done to avoid such break-ups. The writer, ignorant of the functions of a mental hospital social service department, thought that since the family welfare society was unable to avoid the break-up that perhaps the hospital social worker might.

To find out whether the social service worker in a mental hospital could really help in such family break-ups where a mother was mentally ill the writer went to a mental hospital for her second field work placement. She went with the deter-

mination to learn all about the patients and all about the function of the social service department in relations to the patients and their families. At this placement it was the writer's good fortune to have as her most complete case, the second case observed, that of a young mother of two very small children. The writer saw the patient for the first time in staff presentation after having obtained a social history and after having made a home investigation as the patient wished to go home. Later the writer made several home supervision visits. The above services for the patient gave the writer a very good chance to learn about the effect of this mother upon her family. Again, in this patient's case, there was seen a broken home, a harrassed young husband, children scattered about, one with a friendly neighbor and the other in a Catholic orphanage. After leaving the hospital, a short while after the writer finished field work, this patient gave birth to another child. Sometime after its birth she had the other children brought home and set up housekeeping once more for them and for her husband. According to the last reports heard she was proving inadequate because she was neglecting the children, her husband, and her home. This case is still active and is not one of the cases studied.

Here were two cases where the effect of the mother's mental illness and hospitalization meant the break-up of the family unit and the scattering about in institutions and elsewhere of the children. Was this what always happened? To obtain the

answer to this question the writer determined to study statistically as many cases as possible of mentally ill mothers who had children, young children. Hence, this study.

Prior to beginning the study, studies of a similar nature and pertinent literature were sought. Broken homes of interest in this study could only be found as a subject referred to in texts but never as the main subject of texts. Most of the literature and studies about mental illness and the family dealt with inheritance. James S. Bossard says about studies of mental illness and its effect on the family the following:

> There are two distinct aspects to the relationships between the family and mental disorders. One concerns itself with the effect upon the personality and mental health of its members; the other deals with the role of mental disorders in the disorganization of the family. The latter phase has been much less considered than the former. In fact a survey of the literature on the family shows an amazing lack of appreciation of the significance of this latter relationship. Nevertheless, it must be obvious that the mental health of the person is an important determinant in the success or failure of the family life. 1

It is the purpose of this research to note the effect of a mother's mental illness upon the family unit; to note whether she returns to unite her family; to note whether the home is broken up by removal of the children by agency workers and by removal of the mother; to note whether the children continued to live on in the broken home with their father. The writer

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1. James H. S. Bossard, Social Change and Social Problems, p. 503.

observed what happened in several single instances and proposes to learn whether the observations hold for many instances to be seen in a statistical study.

The scope of this thesis takes in all the discharged cases of psychotic mothers, patients in the Metropolitan State Hospital, during the years 1930-1942, who had children under twenty-one at the time of first onset of their mental illness. The patients, all residents of Massachusetts, are "psychotic" as diagnosed by the hospital physicians upon their last admission for those who had more than one--to the Metropolitan State Hospital. There is no limit placed on color, religion, or legal marriage. There is an upper age limit of twenty-one years for a minor. The number of cases found that fulfilled requirements was seventy-two. Throughout the entire period studied the same head social worker, Miss Mary W. Killam, has continued in service, thereby giving the study the benefit of a uniform recording of the notes of the Social Service Department.

It is hoped that one value of this study will be to have people consider approaches to the study of the effect of mental illness upon the family other than the hereditary one. It is hoped that a second value of this study will be to have people consider the question of broken homes in a broader way than only the effect of death or desertion by one parent. The broken home should merit consideration in itself since it is always referred to as an important index of disorganization.

The following are the hypotheses of this study:

a. that broken homes are the result of the mother's mental illness.

b. that younger children are taken by agencies; older children continue to live on in the broken home

c. that a possible influence of the psychotic patient is that she may get all the attention to the detriment of the other members of the family

d. that the rights of normal children are being sacrificed for psychotic patients

e. that the hospital social worker should take some stand or line of action when she is convinced of danger for children to live in such homes as she sometimes finds

f. that the economic status of the family is a contributing factor to broken homes.

CHAPTER II

CONDITIONS OF THE STUDY

The study revolves about the seventy-two psychotic women patients from the Metropolitan State Hospital. This newest of Massachusetts' state hospitals is situated in the city of Waltham which is about an hour's subway and trolley ride from Boston. A small community in itself with its 1900 or so patients rather evenly divided as to sex, it is served by resident workers and by commuting workers. Among these seventy-two discharged patients are some from as close by as the city of Waltham and some from as far away as the city of Fall River.

Coming to this hospital for continued treatment, patients are admitted only as transferred cases from other hospitals. The main building which houses most of the patients is known as the "Continued Treatment Building" or the "Continued Treatment Group" (C.T.G.). In addition, a modernly equipped medical building adequately staffed stands ready to care for any medical needs that may arise among the entire hospital population. Convalescent patients have access to a recreational hall, to occupational therapy rooms, to art classes, to gardening facilities, to a skating rink, to tennis courts--there being trained personnel to teach and to insure their use.

The patients live routinized life. They live an institutionalized life. Some of the patients leave to transfer to another mental hospital, others leave to go to a job placement, still others leave to return to their families, and a few leave

to go to their graves.

To select the seventy-two patients for this study, the writer examined all the female records on file to see whether there would be enough to make a worthwhile study. It was found more expedient to work with only those records in the discharge files. These, it was felt, would be more complete as far as social service notes were concerned and enable a more efficient tabulation of statistics.

Other limitations arose in the course of the study. Among the psychotic mothers of minor children were some diagnosed as having "mental deficiency with psychosis". (Mental deficiency being such a potentially disorganizing factor in itself) the writer thought it best not to include the patients so diagnosed. The question of how to define a minor child soon came to the fore. Because the Division of Child Guardianship maintains supervision over its charges until they are twenty-one years of age, it was decided to make twenty-one the upper limit on age for a minor. Most of the children in this study at the onset of the mother's mental illness were far from this upper limit.

It had been hoped to interview members of patients' families and members of the Hospital Social Service staff in order to present several fairly intensive case studies. It had been hoped to have every case registered at the Central Index March, 1943 in order to get a fully up-to-date picture of agency contacts and dispositions of patients and children. Altogether,

thirty-five were recently registered and twenty-six previously. It should be noted, however, that among those previously registered, only one was as far back as 1916, most of the others being in the middle and late thirty's.

Not being able to read all the records of agencies registered on Index Slips, the writer selected those referring to children such as: Division of Child Guardianship, Society for Prevention of Cruelty to Children, Children's Aid, Boys' Parole. Representative cases were followed through at the above named agencies for use in the thesis. In the hospital records social service notes, abstracts from other mental hospitals, correspondence to, by, and about patients and their relatives were read carefully with an eye to the disposition of the patient, children, and husband.

Diagnoses employed in this work are always the last determined ones noted on the face sheet of the hospital records. In instances where patients had more than one admission in this period of 1930-1942 the age as of last admission was taken. If any terms such as "normal" are used the common sense meaning is to be understood for no special technical or scientific definition is given.

A three-page schedule was drawn up and filled in as adequately as possible for each of the seventy-two cases studied and tabulated.

CHAPTER III

SOCIAL AGENCIES

One of the unexpected, interesting, and pertinent results in this study showing the effect of a mother's mental illness upon the family unit was to find that so many agencies per patient and family were contacted. The many agencies available to the people of Massachusetts obviously were known to the patients and their families. There were, as can be seen in Chart I on page 12, ninety different agencies known to the patients and their families and categorized as follows: children's, hospitals, relief, miscellaneous. It is interesting that the largest group consisting of twenty-five agencies, is that of the children's. The children's agencies give pretty good indication of the effect of a mother's mental illness upon the family unit and what happens to the children. They show that the family can not continue on as a unit without her presence. The next largest group is that of the hospitals, composed of twelve mental and twelve general. The third group comprising twenty-three relief agencies is to be expected in a sample for whom it is recorded that 88 per cent are marginal[1]; 5 per cent dependent.[2] The final category entitled "miscellaneous", frequently containing agencies whose functions perhaps overlap into the agencies listed in the other three groups, demonstrates how patients and their families will turn everywhere

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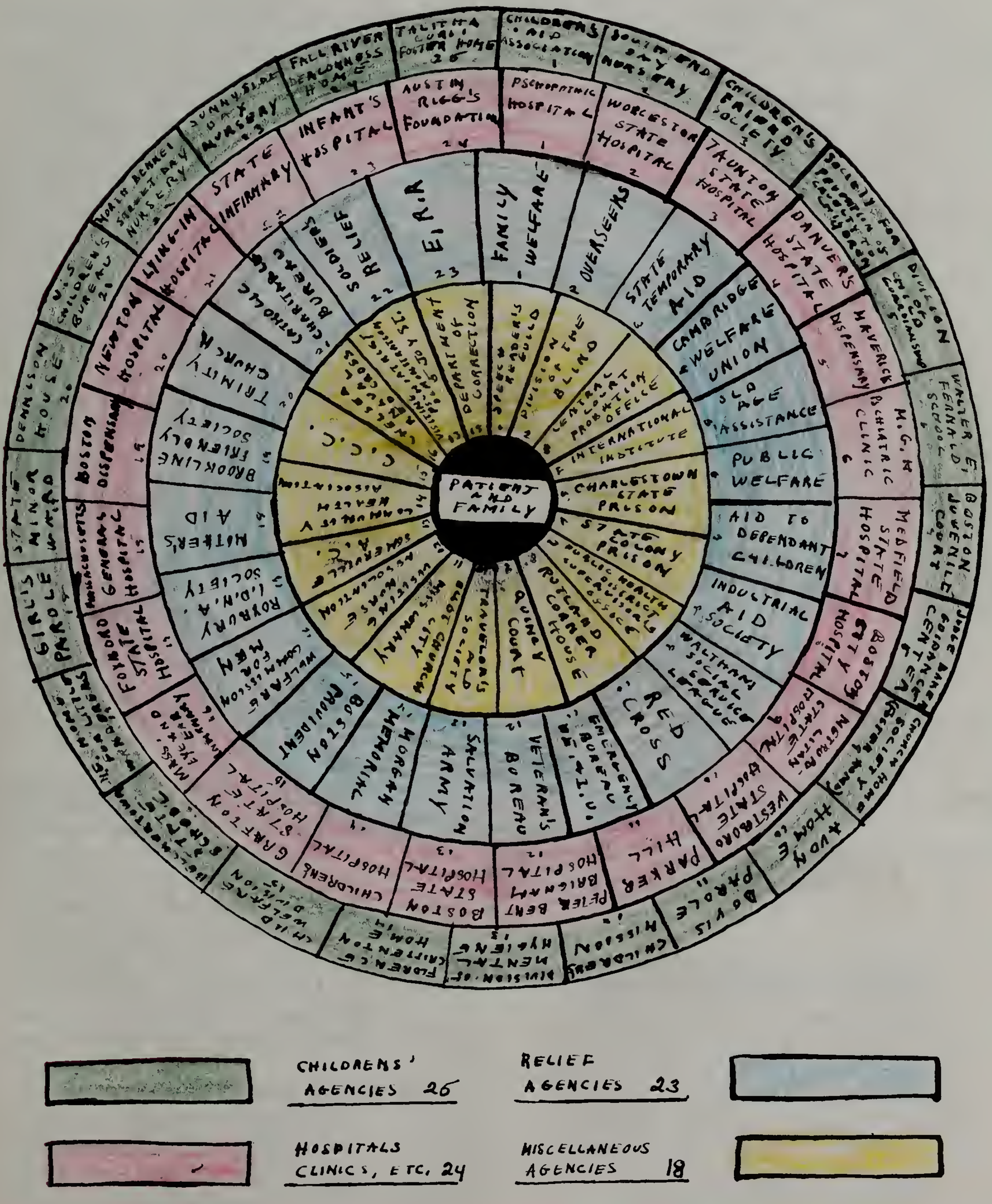
1 See Chart III Infra p. 12
2 Ibid., p. 12

CHART I

THE 90 AGENCIES CONTACTED BY THE FAMILIES OF 61 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.



THE NINETY-ONE AGENCIES CONTACTED BY SIXTY-ONE DISCHARGED PSYCHOTIC MOTHERS OF MINOR CHILDREN WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942 AND THEIR FAMILIES

Children's Agencies
Children's Aid Association
South End Day Nursery
Children's Friend Society
Society for the Prevention of Cruelty to Children
Division of Child Guardianship
Walter E. Fernald School
Boston Juvenile Court
Judge Baker Guidance Center
Church Home Society(Foster Home)
Avon Home
Boys' Parole
Children's Mission
Division of Mental Hygiene
Florence Crittenton Home
Child Welfare Division
Belchertown State School
New England Home for Little Wanderers
Girls' Parole
State Minor Ward
Dennison House
U. S. Children's Bureau
North Bennet St. Day Nursery
Sunnyside Day Nursery
Fall River Deaconness Home
Talitha Curi Foster Home

Hospitals, Clinics, etc.
Psychopathic Hospital
Worcester State Hospital
Taunton State Hospital
Danvers State Hospital
Maverick Dispensary
M.G.H. Psychiatric Clinic
Medfield State Hospital
Boston City Hospital
Westboro State Hospital
Metropolitan State Hospital
Parker Hill
Peter Bent Brigham Hospital
Boston State Hospital
Children's Hospital
Grafton State Hospital
Mass. Eye and ear Infirmary
Foxboro State Hospital
Newton Hospital
Massachusetts General Hospital
Boston Dispensary
Lying-In Hospital
State Infirmary
Infants' Hospital
Austin Rigg's Foundation

Relief Agencies
Family Welfare
Overseers
State Temporary Aid
Cambridge Welfare Union
Old Age Assistance
Public Welfare
Aid to Dependent Children
Industrial Aid Society
Waltham Social Service League
Red Cross
Emergency Bureau W.E.& I.U.
Veterans' Bureau
Salvation Army
Morgan Memorial
Boston Provident
Welfare Commission for Men
Roxbury I.D.N.A. Society
Mothers' Aid
Brookline Friendly Society
Trinity Church
Catholic Charitable Bureau
Soldiers' Relief
E.R.A.

Miscellaneous Agencies
Speech Readers' Guild
Division of the Blind
Central Court Probation Office
International Institute
Charlestown State Prison
State Prison Colony
Public Health District Supervisor's Office

Rutland Corner House
Quincy Court
Traveler's Aid Society
Eliot Church City Missionary
Visiting Nurse Association
Somerville A. C.
Community Health Association
C.C.C.
Chelsea Naval Red Cross
Visiting Psychiatrist Demonstration;
5 Joy Street
Department of Correction

TABLE I

NUMBER OF AGENCIES CONTACTED, MENTAL HOSPITALS INCLUDED AND EXCLUDED, BY THE FAMILIES OF 61 PSYCHOTIC MOTHERS WHO WERE DISCHARGED FROM THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

Mental Hospitals Included			Mental Hospitals Excluded		
Agencies per family	No. of families	Total	Agencies per family	No. of families	Total
0	2	0	0	8	0
1	12	12	1	13	13
2	8	16	2	6	12
3	4	12	3	7	21
4	9	36	4	4	16
5	4	20	5	5	25
6	2	12	6	3	18
7	1	7	7	3	21
8	3	24	8	4	32
9	3	27	9	2	18
10	2	20	10	2	20
11	4	44	15	1	15
12	2	24	20	1	20
13	1	13	24	2	48
16	1	16			
22	1	22			
26	1	26			
27	1	27			
TOTAL	61	358	TOTAL	61	279

for help.

The chart depicted the number of different agencies contacted by sixty-one patients and their families; Table I goes a step farther and considers the number of agencies contacted, mental hospitals included and excluded, by these sixty-one patients and their families. Two do not contact any except mental hospitals. Eight others, if mental hospitals were excluded, would have no contacts with any agencies. The eight who had contacts only with mental hospitals were probably those families where children were near the upper limit for minors, i.e., twenty-one. The largest number of agencies contacted by any one patient and family, mental hospitals included was twenty-seven; mental hospitals excluded, twenty-four. To have so many agencies contact one family is a clear indication of the disorganizing influence of the mother's mental illness upon her family. One might say that this is the exceptional case and an extreme example. This is probably true, but let us consider the average case. The average number of agencies contacted per patient and family with mental hospitals included was 6 1/5 and with mental hospitals excluded was 4 1/2. Although the writer did not investigate the length of time of the contacts made with these agencies it is to be considered as of importance. But whether the contacts are long or short there having been made at all is significant enough of the disturbing effect of the mother's mental illness upon the fam-

ily. Contact of the family with the mental hospital is in itself pretty upsetting to the family and definitely an effect of the mother's mental illness. There might be raised an objection to the use of an average number of agencies per patient and family because averages are weighted by extremes. This sample had extreme cases for many contacts and for few contacts. Yet a glance at table I will show that there were a significant number contacting many agencies to offset the effect of the extremes on our average number of agency contacts per patient and family. Eighteen patients and their families, mental hospitals excluded, contacted six or more agencies and twenty-one patients and their families, mental hospitals included, contacted six or more agencies.

Altogether for these sixty-one patients who were cleared through the Social Service Index there were 358 agency contacts, mental hospitals included; 279, mental hospitals excluded. These results were found by adding up the total of the agencies indicated on slips obtained by registering the patients and their families at the Social Service Index. It should be noted here that every entry was counted on the Index slip even if the same agency were repeated. It was felt that if an agency had to reregister a case that there was probably a lapse in treatment and that it was equivalent to a new agency contact.

It is very clear in the light of the tabulated results that sixty-one of the seventy-two patients and their families were very well known to their agencies. Since so many of these

were children's agencies, one can expect to see them play an important role in the lives of the children in this research. Justine Polier in her book Everyone's Children, Nobody's Child has not failed to note the impact of agencies upon New York children that she has studied.

> A very high proportion of the 58 children covered by this study are the children of poverty and the inhabitants of slum areas. Of 541 children, for whom adequate data were obtained, 346 or 64 per cent came from families dependent on some kind of public assistance. An additional 35 or 6.5 per cent had no ascertainable source of income at the time of court appearance. In addition, it was found that of 493 children, whose families had been cleared through the Social Service Exchange in the course of the probation investigation, 428 or 87 per cent were known from one in 47 cases to nineteen agencies in 3 cases; 206 children were known to six or more agencies. [3]

CHAPTER SUMMARY

An unexpected result of this study as seen by this chapter is the large number of different agencies knowing these families and the large number of agencies contacted per patient and family. There were ninety different agencies divided up into the following categories: children's, hospitals, relief, miscellaneous. For these sixty-one patients who were cleared through the Social Service Index, there were 358 agency contacts, mental hospitals included; 279 contacts, mental hospitals excluded. The largest number of agencies contacted by any one patient and her family was twenty-seven with mental hospitals included and twenty-four with mental hospitals excluded. The average number of agencies contacted per patient

3. Justine Wise Polier, Everyone's Children, Nobody's Child, pp. 92-93.

and family with mental hospitals included was 6 1/5 and with mental hospitals excluded was 4 1/2.

CHAPTER IV

SOCIAL SERVICE DEPARTMENT

Among the ninety different agencies listed the one the writer was most interested in was that of the mental hospital as represented by its social service department. She was interested in a close examination of its function in hopes of finding an answer as to what to do in cases where a psychotic mother's hospitalization leads to a break-up of the family unit and a scattering of the children among various children's institutions and agencies. It is pretty evident from the aforegoing chapter that these children--many of them--were taken by children's agencies. Did our hospital social service department do anything for these children and for the patients with the broken home in mind? Did its function provide for what might happen to a family unit--for the scattering about of the children? With these questions in mind the writer examined the function of the social worker in a mental hospital. The functions of the hospital social service department's workers are well stated in the following report drawn up by the Mental Hospitals Committee of the American Association of Psychiatric Social Workers. Miss Mary W. Killam, head social worker of the Metropolitan State Hospital, was one of the three committee members.

> The primary function of the social worker in a mental hospital seems generally to be accepted as the handling of the social and environmental factors related to the patient's illness. The means of carrying out this responsibility in-

cludes the obtaining of psychiatric social history; the analysis and interpretation of social data; social treatment; and participation in both out-patient and mental hygiene clinics conducted by the hospital staff.

The social treatment of the patient and his family after the patient leaves the hospital will depend on such factors as the patient's mental condition, family setting, proximity to the hospital and availability of community resources. Social treatment will be most effective when the cooperation of the patient and his relatives is obtained. Continued social treatment should be given in some cases, and in other, follow-up visits only are necessary. The latter give the hospital staff information as to the patient's progress and offer the patient and his family the opportunity for reassurance, advice, and help in case of changing circumstances or further difficulty.

Social supervision of convalescent cases may be given by the hospitals or by local agencies carrying responsibility in cooperation with the hospital, but in general it is preferable that supervision of mental patients in the community should be in the hands of psychiatrically trained workers. If the community social worker supervises a patient, there should be careful planning prior to the patient's hospital release to insure understanding of the patient's individual needs, and subsequently, a continuous exchange of information between the community social worker and the hospital.[1]

"The primary function of the social worker in a mental hospital is the handling of the social and environmental factors related to the patient's illness". Even before the patient leaves the hospital the worker is busy performing her function locating and contacting relatives, obtaining permits for lumbar punctures, encephalagrams, biopsies, post-mortems, burials. Such services mean much to patients and relatives helping to maintain connections between the patient and the community.

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1 American Association of Psychiatric Social Workers' Report of Mental Hospitals Committee, A Statement of Commonly Accepted Practices and Standards for Social Service Departments in Mental Hospitals, p. 2

A means of carrying out the primary function "includes the obtaining of psychiatric social history". "Social histories", "partial histories", "additional information" are the captions in table II covering this function. In the case of thirteen of the seventy-two patients under consideration in this paper this function was performed that more of it was not done is due to the fact that this hospital is a continued treatment one; that patients are admitted with social histories already obtained. These are all important services but do not deal with the patient primarily, nor with the effect of her illness on the family unit.

Another means of achieving the primary function of the social worker of a mental hospital is the home investigation just prior to the patient's permission to go home for a visit. Twenty-three of these were made for seventy-two patients. The investigations are very important and often turn the balance of the physicians' decisions as to whether a patient is to return to her family or not. For example in case number 70[2] the hospital worker made a home investigation. This patient was pronounced "recovered" and more ready for the community than most of the others. The home investigation revealed a jealous, resentful housekeeper and a husband unwilling to have his wife back. Because of this home investigation the release of this patient was wisely delayed. This considered the family but it

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2 See pp. 51-52 Infra

TABLE II

SERVICES RENDERED BY THE SOCIAL SERVICE DEPARTMENT OF THE METROPOLITAN STATE HOSPITAL TO 66 OF THE 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

Type of Service	No.
Home investigation	23
Home supervision[a]	43
Location of relatives	16
Personal services[b]	7
Advice in reference to children in home with patient	8
Partial histories	2
Additional information	4
Social histories	7
Contacting relatives	1
Obtaining permits: burial, lumbar puncture, etc.	7
Co-operation with other agencies about children	13
Locating run-away patients	1
Special investigations	3
Supervision and placing in jobs	5
Work with relative of family	1

a Usually a year's supervision means an average of one call a month but there are variations according to the nature of the individual case and some require fewer visits and other many more.

b Personal services include such duties as returning money and jewelry left with the hospital treasurer.

is on the basis of whether it could care for the patient or not. In other words the patient was the main emphasis and not the family.

Perhaps the most frequent service of the mental hospital social worker is home supervision. The table II has forty-three marked in this classification or 65 per cent of the sixty-six cases tabulated. These home supervisions are made if the patient is on visit for a month or longer. There is then, on the average, a home visit to a patient by the worker, of once a month. The frequency will "depend on such factors as the patient's mental condition, family setting, proximity to the hospital, and availability of community resources". Through the expedient of having the patient spend <u>one night</u> in the hospital, before the year out is completed, the supervision visits by the hospital social worker may be extended another year. This obviates the state ruling that relieves the hospital of all responsibility for patients who have succeeded in remaining in the community a whole year. Some patients needing continued supervision refuse to comply with this simple regulation. When such patients need to be readmitted to a mental hospital they and their families find that they have to go through all the legal formalities encountered on a first admission. And in addition, they learn that since the Metropolitan State Hospital is not an admitting hospital they must enter another mental hospital.[3]

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hospital.[3] Since this study was made it became an admitting

In Case No. 18 the patient's husband and children requested that she go home for a trial visit. These children were at the first onset of their mother's illness seventeen and nineteen years of age. At the time of the requested visit they were eighteen and twenty. The husband and the children were most anxious to have her in the home again. Diagnosed as Dementia Praecox, Paranoid Type, "improved" she was given permission to go to her family by the hospital doctors. There was the provision that she should be supervised by the hospital social service worker while at home. During home supervision visits the patient repeatedly expressed to the Worker her intentions of bringing legal suit--when her discharge was final and when she would be legally able to do so--against the state hospital in which she had formerly been a patient. She declared that while there she had been brutally handled and illegally held. Although the patient had nothing but praise for her treatment at the Metropolitan State Hospital the Worker recognized the statements against the other hospital for what they were; manifestations of her illness, paranoid ideas. The husband and the children, finding her declarations plausible, fully believed the patient. Thus when the Worker suggested that the patient's supervision be extended another year by having the patient return to the hospital for an overnight visit, the family refused to comply with the suggestion. This family seemed unable to face the fact that the patient continued to be mentally ill. They believed that they knew more than the hospital doctors and the hospital social workers about the patient. Having adjusted fairly well in the community and not having returned to the hospital at all during the year she was out, this patient was given her final discharge from the Metropolitan State Hospital.

Not very long after a letter desiring information about the patient was received by this hospital from the very hospital where she had been first hospitalized and to which she was now recommitted. A point in this case is that it illustrates the attitude of older children in a family and an attitude of the lay public toward mental hospitals and mental hospital hospital social workers. The manifestation of such attitudes confirms the need to continue education of the public on the subject of mental illness and its effect upon the family unit.

Here the Worker had in mind the family to save it a traumatic experience. This was a recognition of mental illness in a family which the family could not quite accept.

In addition to home supervision the social services include job supervisions and job placements. There were five cases of this service among the sixty-six cases worked with by the Social Service Department. The procedure in such cases is analagous to the procedure in home supervision and home investigation.

In conformity with the primary function of the mental hospital social worker there were many examples of social treatment in behalf of other members of the family independently or in cooperation with agencies in the community. In eight instances advice was given to the patient about handling the children in the home. In thirteen instances cooperation was given to other social agencies working with the children. This latter assistance is more significant when one realizes that most of the hospital contacts are likely to be terminated at the end of a year's supervision. The following case is an instance of social treatment in behalf of the children of the family:

> Case No. 63 The patient forty-seven years of age, having been diagnosed as Paranoid but "improved", after a hospital stay of two years and five days was permitted to return to her elderly husband after signing a pledge. This pledge was not to make any effort for a period of three months to bring into her home any of her three children. One child the oldest, illegitimate, crippled, a behavior problem, was in the Canton School. A second child, feebleminded, was placed in the Walter E. Fernald School. The

third child, normal, was placed in a foster home. Why was there such a condition imposed on this patient before her release? The main reason was probably the incapability of the parents which had been previously demonstrated and had not changed in the two years of the patient's hospitalization. The patient herself of low mentality and the husband too old to work and handle a family did not get along with each other; were continually quarreling. The patient had at one time managed to get her husband committed to a mental hospital where he was found to have a mild case of arteriosclerosis. Throughout the supervision period the Worker exerted her efforts to prevent the return of the children to such parents, advising agencies to whom the patient appealed for return of the children as to the parents' incapability. The children were not returned during the supervision period,but whether they were later is not certain. The following is the list of agency contacts twenty-one reasons proving the unfitness of these parents to care for their children:

Social Service Index as of 3-10-43

8-25-20	Children's Aid
8-25-20	Family Welfare
7-19-21	South End Day Nursery (Cancelled)
9-11-22	Children's Friend
1-16-25	Cambridge Overseers
1-19-25	State Temporary Aid
2-18-25	Cambridge Welfare Union
8-24-27	Speech Reader Guild
10-11-27	Overseers, Boston
1-19-31	S.P.C.C.
6-4-31	Psychopathic Hospital
10-20-32	Division Child Guardianship
6-16-33	Boston O. A. A.
8-18-33	State Temporary Aid
10-6-33	Boston Public Welfare
7-2-34	Walter E. Fernald School
3-18-35	Worcester State Hospital
12-10-37	Boston Public Welfare A.D.C. Transfer
4-17-41	Judge Baker Guidance Center
12-5-41	Boston Public Welfare, A.D.C. Transfer
7-3-42	Division of the Blind

From speculation upon the above list one would assume that the children went home; relief, A.D.C. was obtained for them; delinquency developed and because child involved was a juvenile the court referred the case to the Judge Baker Guidance Center. It seems also that the patient might have been recommitted to the mental hospital. Finally old age probably robbed the sight of the patient's husband forcing

him to apply for aid from the Division of the blind.

This case is one where the main emphasis is on the effect of a mother's mental illness upon the children. Should these children have been returned to the family? The role of the hospital worker was a preventive one in cooperation with what had already been done for the children by workers from children's agencies. The hospital worker comes into the family, as a rule, after other agency workers have taken the children or made plans for them. Her role is generally one of cooperation with workers of children's agencies and prevention of return of children into the home, at least during the time of hospital home supervision visits. The hospital social worker, even less than the family welfare worker, can do little about the broken home that results when the mother in the family becomes mentally ill and has to be hospitalized.

CHAPTER SUMMARY

As seen from the foregoing material the function of the Social Service Department is to handle social and environemental factors related to the patient's illness. Through the various services, e.g. social histories, locating relatives, obtaining permits, home investigations, home supervisions, this function is put into practice. Although the main emphasis of the service is upon the patient in a number of instances advice and cooperation with childrens' agencies were freely given. In case 63 the Worker made special effort to protect the chil-

dren. Being a continued treatment hospital its Social Service Department is usually too late to be the initiator of help for the children of the patients. The mental hospital social service worker in this hospital, and possibly in most hospitals, is more likely to serve in problems of the children in a co-operative role.

CHAPTER V

GENERAL FACTS ABOUT PATIENTS

This research is interested in knowing about the effect of the mother's illness upon the family unit. To better understand the effect it is necessary to know something about them. This chapter, then, aims to present some of the general findings concerning the mothers, as ascertained from the tabulation of the seventy-two schedules. These findings include the diagnoses, residence, nationality, religion, and ages of the patients.

Dementia praecox is the most common diagnosis for the seventy-two patients. The dementia praecoxes number 33 or 46 per cent of all the cases studied. Manic depressives, paranoias, involutionals, are twenty-nine in number or 41 per cent of the seventy-two cases. The tabulations of the diagnoses reveal, more or less, what is to be expected among a group of mental patients in a continued treatment hospital. Dementia praecoxes, generally long-time cases, one would expect to find and expect to find in greatest numbers in proportion to the hospital population.

From where do these patients come? Being a state hospital they may come from anywhere in Massachusetts. Although this hospital was set up primarily for the metropolitan area a count of the cities from which the patients came adds up to no less than thirty-three. Table IV shows the thirty-three cities and towns from which the seventy-two patients came.

TABLE III

DIAGNOSES OF 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

Diagnoses	Number	Total
Dementia praecox, simple	5	
" " hebephrenic	3	
" " paranoid	13	
" " catatonic	11	
" " undiagnosed	1	33
Manic depressive, manic	4	
" " depressed	7	11
Involution psychosis, paranoid type	3	
" " melancholia	5	8
Paranoid with paranoid conditions	10	10
Alcoholic psychoses	4	4
Psychosis with psychopathic personality	1	1
Psychosis with convulsive epileptic disorders	1	1
Psychosis due to other metabolic etc., diseases	4	4
Total	72	72

TABLE IV

THE 33 CITIES AND TOWNS FROM WHICH CAME THE 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

City	No. of Patients
Boston - Proper	13
Roxbury	6
Dorchester	1
Brighton	1
Jamaica Plain	3
Brookline	1
Somerville	6
Haverhill	1
Lowell	1
Everett	3
Chelsea	2
Gloucester	1
Lynn	3
Allston	1
Cambridge	5
Watertown	1
Newton	2
Weston	1
Belmont	1
Waltham	3
Woburn	1
Ashland	1
Arlington	1
Malden	2
Medford	2
Melrose	1
Quincy	2
Milton	1
Rockland	1
North Andover	1
North Wilmington	1
New Bedford	1
Fall River	1
Total	72

Closer study locates them mostly in the metropolitan area. Thirty-three per cent come from Boston. The cities farthest away are New Bedford and Fall River. The table denotes that the sample is overwhelmingly urban. An urban environment is significant in mental illness, Dayton believes:[1]

> THE ADMISSION RATES FOR THE URBAN CENTERS are higher than those of the rural area in all marital groups. However, the urban environment places a greater strain upon the mental balance of the married than upon any other marital group. Mental disorders are forty-two per cent higher in the married from urban centers than in the married from the villages. Residence in an urban community evidently strips off some protection associated with the married.

It is this urban environment that has the small family unit discussed in our introduction.

The largest single nationality block, as can be seen in Table V is the Irish. The Irish and the English contingents jointly account for forty-two cases or 58 per cent of the seventy-two patients studied. This is a large percentage of English-speaking peoples. With so large a group speaking English and having much in their cultures that is common, one can eliminate as factors in a broken home and as factors in the disposition of the children, differences in culture. In most of the other cases the social worker was not too much troubled, judging from the social service records, by lack of English comprehension and English speech. Negroes who might, because of their color, have special reasons for problems, constitute only a

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1 Neil A. Dayton, New Facts on Mental Disorders, pp. 251-252

small portion of the sample. Their breakdowns do not seem to have been associated with the color question. The Negroes in the hospital population are only a very small part and are more than adequately represented in this group of patients studied.

Designating the cases as mothers of minor children indicates that these patients must be fairly young women. However, the stipulation is that the children were under twenty-one at first onset of the mental illness. Table VI gives the ages of patients at the time of last admission to the Metropolitan State Hospital. Only two of the women are in the 20-25 year class, seven are in the 26-30 year class. In the 20-35 year group, there are eighteen psychotic mothers or 25 per cent of the seventy-two mothers studied. In the next three class intervals, ranging from 36-50, very evenly distributed, fall forty-five patients or 64 per cent of the whole seventy-two patients. In the range of 20-50 are 80 per cent of the patients. In the 56-65 interval there were only three cases.

With a growing number of older people and with an increasing life expectancy span there will be 89 per cent of the patients studied here who might reasonably expect a number of more years of life. They will have many years left to influence their families. This may not augur so well for the minor children involved. These patients' children, for the most part, are still far from the upper limit of minority, twenty-one years.

In religion these patients do not present the unusual.

TABLE V

NATIONALITY BACKGROUND OF THE 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS AT THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942. THESE NATIONALITIES ARE TAKEN FROM THE FACE SHEETS OF THE HOSPITAL RECORDS.

Nationality	Number
American	2
Armenian	2
English	22
French	4
German	2
Irish	20
Italian	5
Jewish	4
Lithuanian	2
Russian	1
Scandinavian	1
Slavonic	1
Swedish	3
Negro or African	3
Total	72

TABLE VI

AGES ON ADMISSION TO METROPOLITAN STATE HOSPITAL OF 72 DISCHARGES PSYCHOTIC MOTHERS WHO WERE PATIENTS DURING THE YEARS 1930-1942.*

Ages in Years	Number of Patients
20--25	2
26--30	7
31--35	9
36--40	15
41--45	15
46--50	15
51--55	6
56--60	1
61--65	2
Total	72

* If any of the above patients had more than one admission to the Metropolitan State Hospital during the years 1930-1942 the age at the last admission was used.

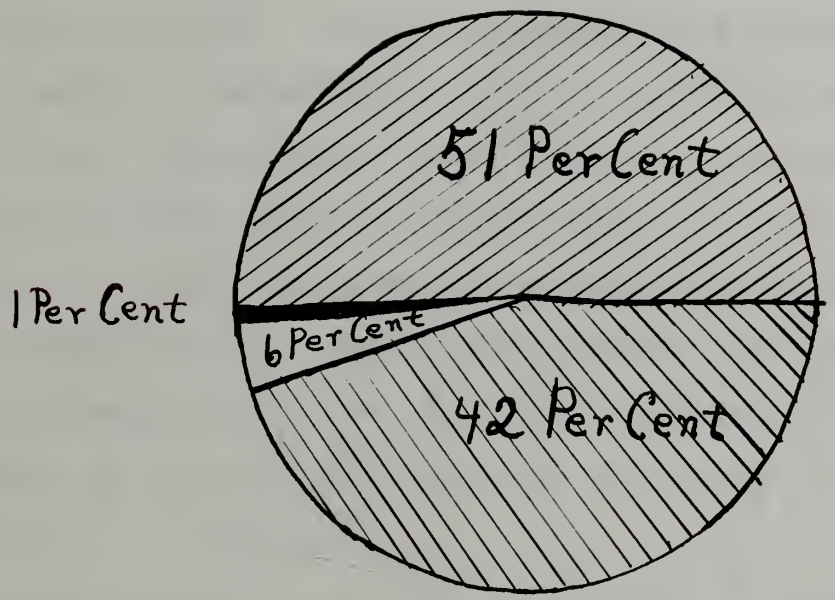
Since so many are Irish in nationality one looks for a large number of Catholics; they total 51 per cent of the group. The next largest group, English, one believes will be Protestant; they are 42 per cent of the group. The Hebrew are 6 per cent, the Orthodox, 1 per cent. To the writer the normalness of the religious factor in the background of these patients eliminates one factor in broken homes. Friction and broken homes largely due to a religious problem would lessen the consideration to be given to mental illness. If strange religious groups were recorded the factor of religious fanaticism might be a real disorganizing one to the families. Here in this sample, as has been said before, there is nothing unusual in the religious background of the patients. This makes more marked the effect of the mental illness and the role it has to play in the lives of the patients and their families.

Another factor was the economic one. The results of this study show the need for more careful consideration of the economic factor. There is not the slightest doubt about the economic status of these patients and their families--not because they are in state hospitals, for even a comfortable family could not long stand the strain of paying for long-time mental illness--but because, as can be seen by the numerous agency contacts, especially relief agency contacts, they really are poor. It must not be overlooked that the cases studied cover the depression years in the period of 1930-1942.

In this study the economic classifications used are those

CHART II

THE RELIGIOUS BACKGROUNDS OF 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.



Catholic		51 Per Cent
Protestant		42 Per Cent
Hebrew		6 Per Cent
Orthodox		1 Per Cent

used uniformly by the hospital, namely, "marginal", "dependent", "comfortable". The definitions for them are those of the hospital. Marginal means "spending just what he makes"; dependent means "living on sources outside of the family"; comfortable means "having enough savings to live on for four months if the income is stopped". Chart III depicts the economic status of these seventy-two patients. Eighty-eight per cent are marginal; 7 per cent, comfortable; and 5 per cent , dependent. Summing up the dependent and the marginal there is a total of 93 per cent of the patients, under the weather, economically speaking. The writer does not overlook the fact that her selection of all the discharged cases over the years 1930-1942 is a small one limited to one hospital which has, as a rule, long-time continued treatment patients.

In reference to this economic status it might be well to consider results found in a somewhat similar study by Smith College student writers of master's theses.[3] The patients they studied were also of state hospitals.

> Another variable possibly influencing the children's adjustment was the social-economic conditions under which they lived. Since the investigation was carried on in a state hospital, there were not many families whose economic situation was above the average. On the other hand, not many were so poor that this factor in itself would account for the children's adjustment. According to a rough classification, thirty-five per cent of the families belonged to the adequate or comfortable economic groups, forty per cent were rated as marginal, and twenty-five per cent were receiving financial assistance.

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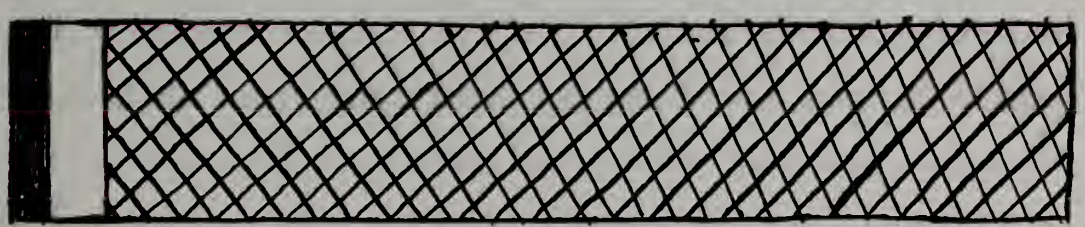
3 Aneita Fanning, and others, editor, "The Mental Health of Children of Psychotic Mothers", The Smith College Studies in Social Work, 8: 299, June, 1938

CHART III

ECONOMIC STATUS AS NOTED ON FACE SHEETS FOR THE 72 DISCHARGED PSYCHOTIC MOTHERS OF MINOR CHILDREN WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.*

Dependent		5 Per Cent
Comfortable		7 Per Cent
Marginal		88 Per Cent



* This is face sheet material from the records of the Metropolitan State Hospital during the years 1930-1942.

In the quoted study 65 per cent were rated, comparatively speaking, as marginal and dependent. This is a much lower figure than the one for this study. The quoted study considers the economic factor as a possible influence upon the adjustment of the children; this study considers the economic factor as a possible influence upon both mental illness in the patients and the disposition of the children. In the above quotation mention is made of 25 per cent receiving financial assistance; nothing is mentioned about other assistance such as aid from children's agencies.

CHAPTER SUMMARY

As seen in this chapter, the patients present nothing very unusual as to religion, nationality, and diagnosis. What has proven to be of significance about these patients is their very poor economic status, 93 per cent being in the combined marginal and dependent class. Two factors that probably account for this situation are: one, that the group was studied during the depression years of 1930-1942; two, that this hospital had long-time cases. This economic status is significant in the disposition of the children. Another matter of significance as brought out by this chapter is the age of the patients. Eighty-nine per cent of the patients are under the age of fifty. This means, now that life expectancy span has increased, that these patients have a good number of years of life ahead of them, years of life to influence further their families.

CHAPTER VI

DISPOSITION OF THE PATIENTS

Let us consider here some of the effects on the family of the psychotic mother whether she stays in the hospital or whether she returns temporarily or permanently to her family. In chapter V the impression has probably been created that this being a continued treatment hospital that most of the patients must remain in the hospital for a very long time. Even though mental illness lasts longer than general illness, time is a relative factor and much dependent upon the nature of the mental illness of the specific patient. In a case of dementia praecox, there is more likely to be a long-time stay over a period of years. Despite the impression created, one can see in Table VII that all patients do not necessarily stay in the mental hospital a long long time.

In consulting the results listed in Table VII, one should observe that the period of years used in the class interval is not inclusive of the upper limit. For example, in the interval of 0---1 months and days up until the first birthday is meant. To shorten the table, from ten years on the interval was increased to a five-year period. To better interpret the table to account for lengthier stay in mental hospitals than would seem possible for the only twelve to thirteen years of existence of the Metropolitan State Hospital, it should be stated that on the face sheets of the hospital records, there are always listed previous hospital residences and total stays. Therefore, bear-

ing these facts in mind, one can readily see how some of the patients managed to have added up fifteen, twenty-five and more years in mental hospitals by the time of and including the time of their stay in the Metropolitan State Hospital. Patient No. 47 spent forty-two years in mental hospitals being discharged only by death. The shortest stay of all the seventy-two cases was one of three months and five days.

All patients fortunately do not need to spend so long a time in mental hospitals. We find nineteen or 26 per cent of the group spending less than two years in mental hospitals. On the other hand, we find twenty-one or 29 per cent spending ten or more years in mental hospitals. In the 10--15 year interval are twelve patients or one sixth of the cases studied.

Sometimes length of stay is not nearly as important as continuity of stay. A patient who goes home and temporarily adjusts, then begins to get disturbed again keeps her family constantly apprehensive. Such visits are decidedly a disorganizing factor to the family. If a patient is always in the hospital, a plan of life at home once assumed can be maintained with some degree of peace and assurance. This is probably what happened in the instance of patient No. 47 who had a continuous hospital stay of forty-two years, two months, sixteen days. The little data that could be had about this patient's family came from the social service notes on location of relatives. The patient was so little a part of her two children's lives that they had long believed her dead. Neither of them could re-

TABLE VII

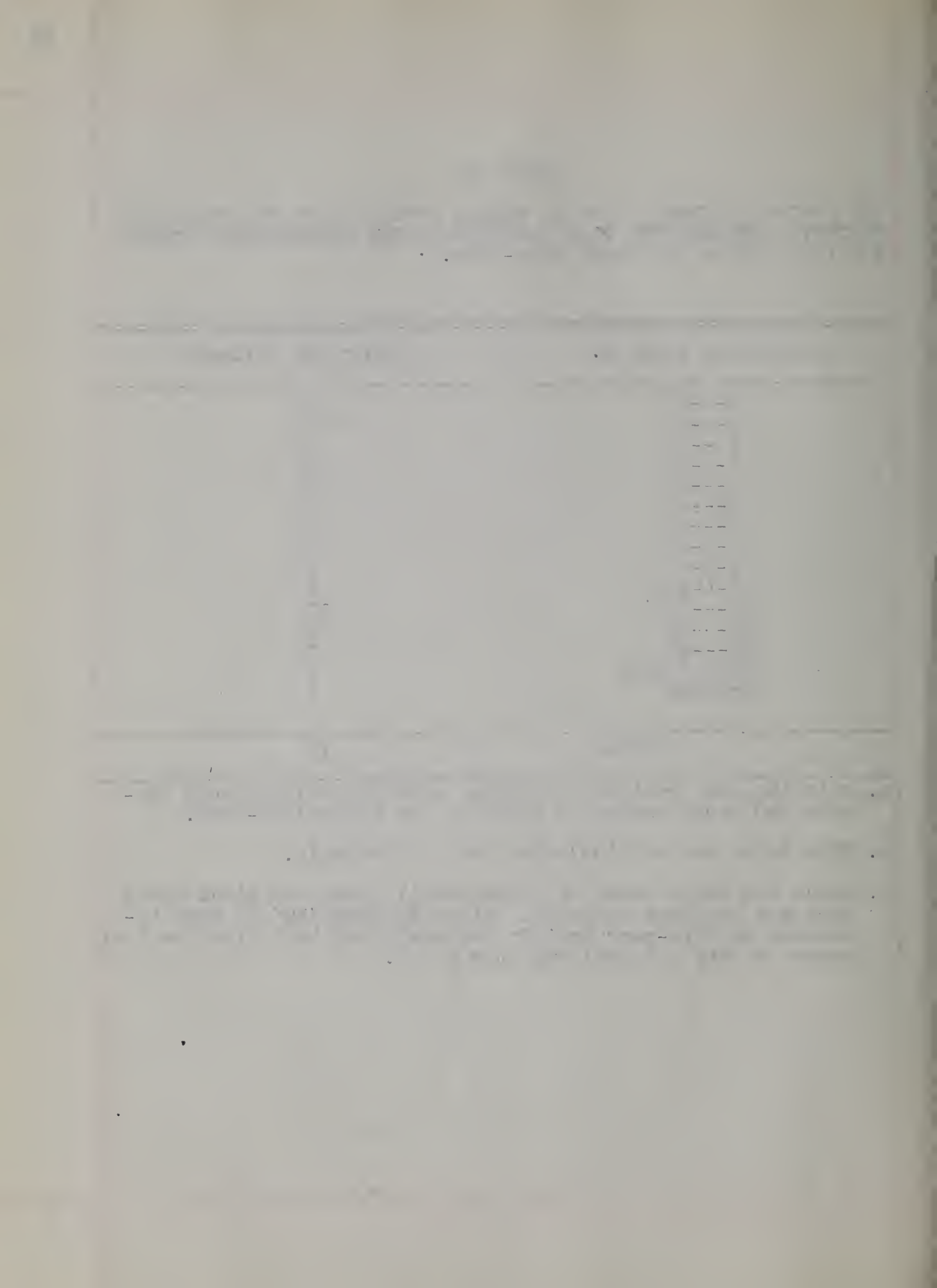
THE NUMBER OF YEARS SPENT IN MENTAL HOSPITALS BY 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.[a]

Period of Years b.	Number of Patients
0---1	9
1---2	10
2---3	3
3---4	4
4---5	7
5---6	5
6---7	5
7---8	2
8---9	1
9---10[c].	3
10---15	12
15---20	6
20---25	2
25 and Over	1
Unknown	2
TOTAL	72

a. This includes residence in other mental hospitals both private and state during or prior to the years 1930-1942.

b. This is to and not inclusive set of intervals.

c. Since the table would be unnecessarily long and since there were not too many cases the intervals from "10" on were increased to five-year periods and again not including the last number of the interval but only to it.



call what she looked like. Their father only occasionally made reference to her. Table VIII discloses that forty-one patients have had a continuous hospital stay, that is, no breaks to return home to their families. In this group are contained some who are in a mental hospital for the first time. Some of these patients since their discharge may have gone home and been returned through legal commitment to another mental hospital. They would, if this is the case, then be listed in the discontinuous category. In this latter category are listed twenty-four patients. They are the ones who shuttle back and forth between the hospital and their homes or between the hospital and their jobs, as the case may be. For seven of the patients the writer could not definitely determine their type of hospital stay.

Although all the cases are discharged, it is not to be assumed that they were discharged into the community; some were transferred to other mental hospitals.

What is the condition of the patient on discharge? Table IX shows that the largest group is discharged as "improved". This does not mean cured nor does it preclude the possibility of a relapse. "Improved" is a term somewhat analagous to that of "arrested" used in the discharge of tubercular patients. Twelve of the patients or 16 2/3 per cent died; another twelve or 16 2/3 per cent were transferred as "unimproved" to other mental hospitals. Only six or 8 1/3 per cent left the hospital as cured or "recovered". This latter is not so strange when one

TABLE VIII

CONTINUITY OF RESIDENCE IN MENTAL HOSPITALS OF 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.[a]

Continuity	No. of Patients
Continuous	41
Discontinuous[b]	24
Not known	7
Total	72

a. Some of these patients continue on in hospitals for some of the discharges were not to homes or death but transfers to other mental hospitals.

b. Patients who are listed as discontinuous may also have had several hospital transfers.

TABLE IX

CONDITION OF THE 72 DISCHARGED PSYCHOTIC MOTHERS ON THEIR RELEASE FROM THE METROPOLITAN STATE HOSPITAL WHERE THEY WERE PATIENTS AT SOMETIME BETWEEN THE YEARS 1930-1942.

Condition on Release	No. of Patients
Improved	40
Recovered	6
Death	12
Unimproved and transferred to:	
Tewksbury	7
Worcester	1
Foxboro	1
Danvers	1
Taunton	1
California	1
Unknown	2
Total	72

TABLE X

DIAGNOSES AND LENGTH OF STAY IN HOSPITALS OF THE 6 RECOVERED CASES OF THE 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930--1942

Diagnosis	Length of Stay in Hospitals			
	No.	Years	Months	Days
Manic depressive, depressive	1	6	5	3
Manic depressive, manic	1	3	6	8
Involutional Melancholia	1		11	3
Psychosis due to other metabolic, etc., diseases	1		6	15
Psychosis due to other metabolic, etc., diseases	1		5	22
Alcoholic psychosis	1		7	10
Total	6			

considers that at this hospital for continued treatment are many long-time cases.

Further investigation of the six recovered cases discloses that they are, as may have been conjectured, in the group having shorter stays in mental hospitals. One of them, however, had a long stay, spending six years, five months, three days (discontinuously) in mental hospitals. The shortest stay of this group of six was for five months and twenty-two days. The diagnosis for this latter patient was "Psychosis Due to Other Metabolic, etc., Diseases: with Diseases of the Endocrine Glands (Pregnancy)". Cases diagnosed as manic depressive, both manic and depressive stages, involutional melancholia, psychosis due to other metabolic diseases, and alcoholic psychosis all have a very good chance of recovery. They are the diagnoses for the six recovered patients. It is to be noted that not one case of dementia praecox was to be found in the recovered class. Again we must not overlook the fact that these are only six cases out of a small sample of seventy-two cases.

Some of the patients died, some were transferred to other mental hospitals, but a sizable number, thirty-two or 44 per cent, returned to their husbands and children. Such patients included the recovered and many of the improved. In some instances such a return to the family proved to be the best possible step for both the patient and her family. In other instances it proved a good step for the patient but not so for the family. The following is an instance of the former. In it

TABLE XI

THE TYPE OF FAMILY UNITY AND DISPOSITION OF SOME OF THE PATIENTS IN THE ASCERTAINABLE CASES AMONG THE 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1943.*

Disposition of Patient and Type of Family Unity	Number of Families
Families including children, husband, and patient	32
Families including patient, children, and others	13
Families including patient and children	4
Families including patient, husband, and children	5
Families including patient, children, and others	4
Families including husband, children, and others	2

* Twenty-three patients never returned to any family situation some never having had a family even before hospitalization. Twelve other patients died two of whom died at home while on visit. Fourteen other patients were transferred to other mental hospitals.

is illustrated social service home investigation and home supervision and co-operation with outside community agencies.

Case No. 70 This patient diagnosed as Manic Depressive Psychosis, Depressive Type, had a discontinuous hospital stay of six years, five months, three days; she was thirty-five years of age on admission to the Metropolitan State Hospital. She was English Protestant coming from an urban city within easy commuting distance of Boston. Like most of the patients her economic status was marginal. At the time of the home investigation there were four children, three of whom were at home with the father, a housekeeper, and the housekeeper's young daughter. The children were fourteen, eleven, and nine years of age. Another child of three boarded out since infancy was not in the home. According to the March, 1943 clearing at the Social Service Index eleven agency contacts are listed. Subtracting mental hospitals from the list there remained eight agencies, among them two relief, three children's.

To make matters worse, although the patient pronounced recovered and ready for discharge, the Worker in the case upon home investigation learned that the husband was quite pleased with the housekeeper, displeased with the prospects of the patient's return having been a failure in a previous trial visit. He was, therefore, not all disposed to take home the patient. For awhile nothing further was attempted. Later, after having been informed by an S.P.C.C. worker that her agency was interested in the housekeeper and planned to remove her from the home, the hospital worker again made a home investigation. The housekeeper, a feeble-minded woman, mother of two illegitimate children was sent to Tewksbury by the S.P.C.C. The patient's husband had become tired of her having observed her jealousy of his children but did not know how to get rid of her. The hospital worker noted that the house was situated on a busy street near a business section where there was much auto and trolley traffic. Houses were generally tenement and apartment style, the one of the patient's being a brick tenement house. There were four rooms, electricity, modern plumbing, a coal and gas stove. The house was neat, orderly, fairly comfortable. The neighbors were "lower middle class". The children were anxious for the patient's return.

The patient, on home supervision visits, it was observed, soon took over active management of her home and family. She was pleased with the children's good scholastic standing and their activity in church groups. What was surprising was to have the patient's husband display model behavior, taking the patient out to the movies, staying at home other

nights, attending church regularly with the patient. By the end of the year this patient had made an excellent adjustment expressing gratitude for the help of the agencies and the hospital in getting rid of the housekeeper and establishing her once more in her rightful position in her own home. A 1943 index taken gave no indices to indicate possible breakdown or need of any other agency help for this patient and her family.

In Chapter VIII Case No. 62 is an example illustrating that a patient may return to her family without such good results as in case No. 70.

CHAPTER SUMMARY

This chapter discusses stays in hospitals, discharge condition, and disposition of the patients. The shortest stay of any of the records examined was one of three months, five days; the longest was one of forty-two years, two months, sixteen days. The longest was continuous; the shortest discontinuous. Discontinuity of stay is more disastrous to the family than is a very long continuous stay. This is shown in case No. 70 when the first visit home of the patient proved to be disastrous, leading to an unfortunate chain of events later to be discussed in the chapter on the children. One result discussed in this chapter was that of bringing into the home a housekeeper who had to be taken out by the S.P.C.C. Most of the patients upon their discharge were "improved" which may mean either eventual recovery; no improvement, or a relapse. Only six of the cases were "recovered". Many patients return to their homes some making a good adjustment, some making a poor adjustment with subsequent effect upon their respective families.

CHAPTER VII

GENERAL FACTS ABOUT CHILDREN

In this chapter let us consider general facts about the children who help to make up the family unit; they are the ones, perhaps, who will most drastically feel the effect of their mother's mental illness. Much of the mother's background, naturally, will carry over to the children, e.g. data on religion, on nationality, on economic, status, on length of stays in mental hospitals, on the disposition at discharge. All this gives an inkling of what to expect of the children and their subsequent disposition. We know that for many of the children the home is forever broken; that some probably never had a home with their own parents; that for some the family would temporarily be united until broken up by rushing the patient back to the hospital. We know, too, judging from the ages of the mothers, that most of the children are not very old. In the chapter on agencies we learned that many of the children were known to social agencies such as the Division of Child Guardianship, Children's Aid, Child Welfare Division, Society for the Prevention of Cruelty to Children. The coming in of these agencies into the home signified that there was an interruption in the care of the children or neglect of the children. This background of the family and the mother is especially important when one considers the impact of the mother's personality on her child. If the mother's attitude and personality determine her response and treatment to her

child in a normal family group,[1] it follows that it will equally determine her response and treatment to her child in a family group disturbed by her own mental illness.

Many of the one hundred eighty-two living children of these psychotic mothers were very young at the onset of mental illness. Twenty-seven at that time were one year and under in age. The ages given for the children in this table are the ages at the time of the mother's first attack of mental illness. This was the basis used in selecting the cases for the thesis. Sixty-one or 54 per cent were under the age of five. One hundred thirty-nine children were under sixteen, constituting 76 percent of the total number of children. The one hundred thirty-nine children constitute 89 per cent of the one hundred fifty-six children whose ages are definitely known; for twenty-six children the ages are not definitely known. The per cents used here are for the one hundred eighty-two children except when designated as otherwise. Only 7 per cent are seventeen years of age and over. For the twenty-six or 17 per cent the ages are not definitely known, but from material in the records it has been assumed that the children were minors at onset of mental illness. The ages of the one hundred eighty-two children are given in Table XII.

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1 Mary M. Shirley, Ph. D. thesis, "The Impact of the Mother's Personality on the Young Child", Smith College Studies in Social Work, 12:15, September, 1941.

TABLE XII

THE AGES OF 182 LIVING CHILDREN AT THE TIME OF FIRST ADMISSION TO A MENTAL HOSPITAL OF 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

Years of Age	Number of Children
1 and under	27
2	9
3	9
4	6
5	10
6	8
7	7
8	9
9	4
10	6
11	9
12	8
13	8
14	10
15	5
16	4
17	5
18	0
19	1
20	1
21	2
Over 21	3
Unknown	31
TOTAL	182

The purpose of this study is not to find out about the hereditary aspect of mental illness; whether children of psychotic mothers must necessarily display some emotional maladjustment, nevertheless, it should be mentioned for any possible bearing upon the disposition of the children. In several studies about children of psychotic mothers,[2] the authors came to the conclusion that the children are just like other children, normal. Hospital and agency social workers, judging from this study, would concur in such a conclusion.

> So far as we know, only 8, or 2 per cent of the 377 children living at the time of our first study was published [1923] have up to the present time become committedly insane. This may be too optimistic a conclusion, but we submit it on the supposition that news of a commitment would be easiest to gather, and we know of no more than these eight.

These one hundred eighty-two children one might fairly say, then, at onset of their mothers' illness were a normal group. These children differed from other children in their respective neighborhoods not economically, not religiously,etc. but primarily because their mothers were mentally ill. The children were aware of this difference.[3]

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2. Edna M. Lapron, "Children of Schizophrenic Parents: Present Mental and Social Status of One Hundred Eighty-six Cases", Mental Hygiene, 17: 82-89, January 1933.
Myrtelle Canavan and Rosamond Clark, "The Mental Health of 463 Children from Dementia Praecox Stock", Mental Hygiene,7: 137-147, 1923.
_____,"Mental Health of Children of Dementia Praecox Stock", Mental Hygiene, 20: 463-471, p.471,1936.

3. A. Fanning, Op. Cit. pp. 341-342.

> . . . It seemed most significant that even among the well-adjusted children, there were traces of the same difficulties that were found in more marked degree in the other cases. Most of them were concerned about their mothers' illness. Some gave evidence of being worried about the possible inheritance of mental disease. Many had to assume household responsibilities that more or less interfered with their school and social life. To their social relationships the mental illness was frequently a handicap. People looked upon them with suspicion and were prone to interpret minor difficulties as indicative of hereditary instability. The children were frequently ashamed of the situation, tried to hide it from their associates, and were often embarrassed by the mother's behavior if she was at home and disgraced by her hospitalization. That so many children were able to work out a satisfactory adjustment to such handicaps seemed attributable to their having found a mother substitute in some person in or out of the family.

As a little added emphasis to the quotation, let the reader remember that in this small study, one hundred eighty-two children are involved; that no less than thirty-two patients returned to their husbands and children.

CHAPTER SUMMARY

In this chapter it is shown that the one hundred eighty-two living children of the seventy-two psychotic mothers have the same religious, economic, national backgrounds as the patients. We know that 76 per cent of the total number of one-hundred eighty-two children are sixteen and under at the time of mother's first onset of mental illness. Since the ages for thirty-one of the children could not be definitely ascertained from the records this 76 per cent becomes 92 per cent of the one hundred fifty-one ages ascertainable. These children were mostly minors, not near the upper limit of twenty-one at first onset. These children it is assumed from the material avail-

able in records of the hospital and other agencies read, and from other studies read, probably do not differ markedly from children whose parents have no mental illness.

CHAPTER VIII

DISPOSITION OF THE CHILDREN AND CASE STUDIES AS FOLLOWED FROM HOSPITAL AND CHILDREN'S AGENCY RECORDS

In this chapter we consider what the effect of the mother's mental illness has been on what happens to her children. What happens to the children is an important index of the effect of mental illness, the writer believes. In Chapter VI the disposition of the patients was discussed and case examples cited. Of course the separation of the disposition of the children and of the disposition of the patients is in many instances highly artificial. In many, the disposition of both are interdependent. Some patients return home to a family only changed by her absence; the children having continued on in the home. Table XIII gives seventy-nine children as having remained at home with their father. This does not give the whole picture, however, as in some families, only the older children stay at home while the children too young to be deprived of a mother's care are boarded out, or taken by agencies for children. For instance, to continue on with Case No. 70 discussed in chapter VI, let us see what happened to her children when she was first hospitalized and subsequently.

> One daughter was taken by a friend. After contact by the father with the Division of Child Guardianship and the Children's Aid Association, one son was placed in a home for children; an infant daughter was placed in a home to board. The oldest son remained with the father. This was a broken home, broken by the mother's hospitalization for mental illness. The younger children's disposition was dependent upon the mother's hospitalization. Later, the father employing a housekeeper brought all but the youngest child together again. This housekeeper was disposed of

just prior to the patient's return. The return of the patient made complete the family unit except for the continued absence of the youngest child. At first because it was not surely enough known how the patient was to adjust, the hospital worker advised leaving this youngest child in the good home it had. Later in checking through the Division of Child Guardianship records, it was learned that the couple so loved the child that they had made plans for her education and wished to adopt her. Since another child had been born, and since all concerned thought it best for the child, the parents quietly permitted this child to be legally adopted. The mother and the child never really knew each other; the father who saw her prior to the adoption saw her as a stranger.

TABLE XIII

THE DISPOSITION OF 182 CHILDREN OF 72 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942 WHEN THESE PATIENTS WERE FIRST MENTAL HOSPITALIZED.

Disposition of Children	Number of Children
Taken by family friends	2
Taken by family relatives	20
Boarded out by family	8
Placed in an orphanage	7
Foster home	5
Taken by a children's Agency	28
Adopted	1
Remained at home with father	79
No disposition noted in records	26
Goes home with patient born in hospital (mental)	2
At home because born while patient home on visit	4
Total	182

In table XIII twenty-eight children are listed as having been taken by agencies. Some agencies take these children for long periods of time up until their majority is reached, i.e., up until their twenty-first birthday. Agencies that do this are the Division of Child Guardianship and the Division of Child Welfare of Boston. In Table XIV that further breaks down these children's agencies, it can be seen that nineteen patients and their families contacted the Division of Child Guardianship and twelve contacted the Child Welfare Department. The Society for Prevention of Cruelty to Children has the most contacts with its total of thirty-five.

The Case No. 42 describes the long-time care given to one of the Wards of the Division of Child Guardianship as taken from that agency's records. The child, the only daughter of a patient who was discharged for transferral to another hospital is the subject of the case studied. The patient upon leaving the Metropolitan State Hospital had already spent twelve years, eight months, one day in mental hospitals. Doubtless, she has been accumulating more years in the hospital to which she was transferred. The Social Service Index had the following listed and they tell the story of the case: Westboro State Hospital, Framingham S.P.C.C., D.C.G. They relate that the mother was committed to a state mental hospital; that the child was then taken in custody by the S.P.C.C.; that next she was placed in the guardianship of the D.C.G. The following summary is that of the Division of Child Guardianship:

TABLE XIV

THE TYPE OF CHILDREN'S AGENCIES AND NUMBER ACCORDING TO LISTINGS OBTAINED AT THE SOCIAL SERVICE INDEX FOR THE FAMILIES OF 61 DISCHARGED PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL DURING THE YEARS 1930-1942.

Agency	Contacts *		Mental Hospitals	
	No.	Per Cent	Incl	Per Cent Excl
Division of child guardianship	19	5		7
Society for the Prevention of Cruelty to Children	35	10		13
Child Welfare	12	3		4
Children's Mission	8	2		3
Children's Aid Association	10	3		4
Homes, nurseries	17	5		6
Total	101	28		36

* Total Contacts with mental hospital included were 358; mental hospitals excluded were 279.

How Received Neglected
Family circumstances then and now At the time of commitment the girl was living with an aunt who was unable to keep her. The mother was an inmate of Westboro Hospital and father deserted. Mother is now in Metropolitan State Hospital.
Mentality Good
Education Ninth grade
Training Hairdressing, manicuring, dancing
Employment Manicurist in beauty parlor
Character Good
How many foster homes? Four
Bank Account $167.34
Plan for future Girl lives alone in a little two-room apartment, and is continuing to work in a beauty parlor. She keeps in touch with father and mother.
Prognosis An attractive girl with considerable poise. She is capable at her work and clever in making the most of her clothes. She is now studying ballet dancing.

In the above summary the most interesting item is the question asking how many foster homes. Evidently shifting about to foster homes is commonplace among such children. The answer for this daughter of one of the psychotic mothers was four. In reading the records the various foster mothers described this girl as being saucy, impudent, able to be nice if she cared to be. In other parts of the record it is commented that the girl is close-mouthed, sensitive and shy, ashamed to be behind in school, a condition partly resulting from shifting foster homes. The changing about from foster home to foster home is not unusual for children under twelve who come originally from a broken home.[1] Baylor and Monachesi apply this generalization more to boys than to girls but it fits well into this girl's experience.

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1. Edith M. H. Baylor and Elio D. Monachesi, The Rehabilitation of Children, p. 147.

Case No. 42 delineated the long-time care of a child of a patient who never was well enough to return home to resume care of her child. Case No. 62 is that referred to as one in which, although the mother does improve enough to return and to resume her role of mother, it would perhaps have been better for the children if they had, like the child above, remained in the custody of an agency.

Case No. 62 This patient upon request of her husband after having been declared improved was permitted after a total stay of four years, seven months, ten days to return home. She, too, like Patient No. 70 was young, her age being thirty-four. Her diagnosis as last determined was Dementia Praecox. The hospital worker in her visits to the home during a year's supervision observed the home, the patient, the children. The house had five light, airy rooms in the third floor tenement house owned by the patient's husband. On the first floor lived relatives with whom two of the patient's four children had temporarily stayed during the patient's hospitalization. At one time all four children had been sent to the Home for Destitute Catholic Children. Later two of the children were placed in foster homes. Soon after her return the patient had all the children in the home with her. The patient was ambitious for her children. During the year of supervision she had the family move down to the first floor, bought new furniture a bedroom set and a piano for one of the children to practice music lessons on. Several of the other children were taking music lessons on other instruments, e.g. violin.

In the light of subsequent developments in this case comments about the relationship among the children, husband, patient made by the Worker are of value to note here. On one visit the Worker wrote "Her children are a very lively, talkative, active group and appear somewhat undisciplined but at the same time it is the Worker's impression that they are sincerely fond of their mother and are rather wholesome in their general make-up." One of the children suffered from enuresis and spells thought to be epileptic. Another one of the children used to retort to his mother's scoldings with threats of returning to the lady with whom he used to board who promised to adopt him. The patient did not exclude her husband from the scoldings and quarrelled with him to such an extent about economic condi-

tions and fear of losing the house that the children would tell her to stop worrying about the house.

While the patient was home another child was born. At the end of the year the patient having made an adequate enough adjustment was given her discharge. This discharge became effective in 1931 when her children were eleven, eight, seven, and less than a year old respectively. In March 1943 twelve years after discharge from the Metropolitan Hospital the following agencies were listed at the Social Service Index for the patient and her family. Those after 1931 are of note:

1935 Boys' Parole Board
1941 Central Court Probation Office
1942 M.G.H. Psychiatric Clinic

In addition to the developments in this patient's family since her discharge in 1931 is a letter in February 1943 sent to the Metropolitan State Hospital from The Reformatory for Women about one of the daughters.

Translated in terms of the case these agency listings and the letter tell a sad story of the disposition of this patient's children, as can be gleaned from having followed up some of the agencies especially the one for Boys' Parole. Two of the boys, at different times, were delinquent having stolen. Both of them eventually served time in the Lyman School. A daughter at the age of eighteen was only recently sent to the Reformatory for Women on a charge of being stubborn and disobedient. The patient's husband also broke down under the strain of events and went to the Massachusetts General Hospital's Psychiatric Clinic for observation.

The record at Boys' Parole mirrors frankly the intolerable conditions in the patient's household that led to such unhappy results above listed. The social worker present at one of the quarrels of the patient with her husband saw her throw a loaf of bread at him. The social worker could not persuade her to make any compromises in her dealings with her children. For instance the worker suggested that if the son was to give her all his pay, she should in turn give him some spending money. The children declared that they liked their father best. At one time one of the boys ran away unable to stand the intolerable conditions at home. The patient continued to be a most disturbing factor in her family group.

When one recalls the observations of the hospital social worker one realizes that the patient then exhibited behavior

denoting with trouble for the future of her family. Social workers are not crystal gazers and the future could not be definitely foretold. In this case the patient's return proved detrimental to the family. The loss of the house and economic worries played a strong role in the patient's becoming so worried that she drove her husband and children to ruin. Yet what could have been done by the worker even if she knew definitely what was to happen? There were at the time of discharge no grounds that the patient would have accepted as a basis for reference to the guidance and supervision of another agency. Then again would this patient have accepted such help? For later when trouble had already developed and workers tried to reason with the patient she proved not amenable to suggestion. What preventive work could have been done? What would the role of the psychiatric social worker be? One of the studies about the children of psychotic mothers considers the position of the psychiatric worker.[2]

> From the point of view of the social case worker the most important finding was that the great majority of the children...stood in need of help of some sort. The problems of some of the children were clearly very complicated and probably required the help of a psychiatrist, but there were many children whose adjustment was fairly good who might nevertheless have been unable more satisfactorily to deal with their anxiety if the services of the case worker had been available to them or to their relatives. The students who made the investigation are inclined to think, however, that many of the families would have rejected an offer of assistance, partly because of its mental hospital

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2. A. Fanning, editor, Op. Cit. pp. 342-343.

connotation. This is a conclusion that cannot be accepted without further study, of course, but it did appear to us that the question of the role of the psychiatric worker with children of psychotic parents was an important one for the profession to consider.

In reference to the case just narrated two other studies read discuss the harmfulness of the mother's presence in the home. The authors believe the mother's presence can be detrimental to the adjustment of children. One author thought that children could be helped in case work treatment when they were removed from the mother's presence.[3] The other author suggested as a result of her research that more attention be paid to the influence of the psychotic mother on members of the family who might be the source of stability and security to the children. In our case if the patient's husband had not been nagged and berated by her, he would perhaps, have been according to the second author, a potential source of stability and security for his children. Be it remembered that the children preferred him to the patient. These are interesting and worthwhile suggestions and merit more study.

As this is a chapter on the disposition of the children of psychotic mothers it might prove of value to give as our

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3. Harriet S. Lybyer, "The Work of a Family Agency With Psychotic Individuals and Their Families"(A thesis) Smith College Studies in Social Work, 10:98, December 1939.

4. Jane Ludy, "Social Adjustment of Children of Psy-Mothers", Smith College Studies in Social Work, 10:148, December, 1939.

final example the case of patient no. 36 who is the mother of nine minor children.

> This patient upon admission to the Metropolitan State Hospital was forty-four years of age and already have given birth to the whole nine children. Her diagnosis was Paranoia and Paranoid Condition; Paranoid Condition. Her hospital stays--not continuous at the time of discharge totaled five years, seven months, ten days. Her case is definitely one that illustrates the unfortunate results that occur when a patient who does not have a continuous stay comes home, goes back to the hospital, comes home. Her shuttling back and forth into and out of hospitals, being kept track of by agencies like the S.P.C.C. make for hectic family life and additional children to be taken up on charges of neglect. She was the mother of seven, when she was first hospitalized. Their ages then were 12, 11, 9, 7, 5, 3, 1 respectively. Upon her second hospitalization five years later she was the mother of nine. They were then 17, 16, 14, 12, 10, 8, 6, 3, 1 respectively. Two years later at the time of her third hospitalization they were still minors. The economic status of this family was dependent. The patient had been Catholic prior to marriage changing at marriage to become a Protestant. She was of English-Irish mixture. The family was known to seventeen agencies and predominant were the listings for the S.P.C.C. The records of the latter agency were followed. It was active in the case from the first hospitalization of the patient. Their case work appraisal of the case is: 1. Probelm--Mother insane; children physically neglected because of mother's mental condition. 2. Accomplishment--Mother committed to Foxboro State Hospital. Seven children placed with City Institutions Division as dependent. The first contact with this agency came about when the public health nurse sent the patient's husband to them to get assistance in cleaning up the home which was in terrible condition because of patient's inability to care for it. The agency contacted a family welfare and had an emergency week-end food order sent to the family. They had the mother hospitalized and the children placed as noted above under "accomplishment". Then three years later with the seven children still in the custody of the City Institutions Division and Division of Child Guardianship the Society for the Prevention of Cruelty to Children learns that patient mother of an eighth child had been camping out in New Jersey and neglect again is implied. A few years after this, the patient now the mother of two children other than the seven still placed with the agencies. is back in Massachusetts having recently returned from Washington where she and the children had been abused and

neglected. At this time the mother was rehospitalized and the last two children placed in boarding homes having been taken as neglected children. The last two children came to the attention of the hospital social worker when the father having reclaimed his seven children and set up housekeeping with a cousin who had formerly been an attendant in a mental hospital asked to have them. The hospital worker consulted the patient who preferred to have them left in the homes in which they were placed. The father had desired to take them to California where he planned to live feeling that he could manage better financially there.

The patient was discharged "unimproved" to go to a California state mental hospital. Her husband and nine children finally established themselves in California and the cousin continued to serve as housekeeper. She wrote to the hospital saying that by keeping on a budget the family was managing to get along much better than ever before. This marks the end of the disposition of this family and patient as far as can be known in Massachusetts.

Let us consider the table on the disposition of the children. Of the one hundred fifty-six children whose disposition is known 45 per cent, almost half, or seventy-one of the children are not in their homes. Seventy-nine or 51 per cent remain with their fathers usually in the home. Twenty-eight are taken by agencies for children, this being probably an underestimate. It is likely that many of the children as listed with their fathers have also had something to do with the many children's agencies, and may have been away in foster homes a while at least.

CHAPTER SUMMARY

Of the one hundred fifty-six children for whom a disposition is given 45 percent are taken from the home either by friends, relatives, foster parents, orphanages, or agencies.

Fifty-one per cent of the children remain with their fathers--but they may be,as a rule,the older children of the family.

CHAPTER IX

CONCLUSIONS

It is the purpose of this research to note the effect of a mother's illness upon the family unit; to note whether the home is broken up by the removal of children by agency workers and by the removal of the mother; to note whether the children continued to live on in the broken home with their fathers.

The writer now in a summarizing fashion takes up some of the separate results relative to our conclusions that were brought out in the preceding chapters.

Agencies

Our chapter on agencies provided indication of the effect of a mother's mental illness upon the family unit. Although ninety different agencies were contacted by the sixty-one patients and their families for whom statistics were available, it cannot be concluded that all were contacted because of a mother's mental illness. For example, contacting relief agencies may have no connection with the mother's mental illness. Contacting miscellaneous agencies such as the International Institute may have no connection mother's mental illness. Contacting children's agencies may be definitely connected with the mother's mental illness and in the cases studied in this research often directly connected with it. Contacting mental hospitals is definitely connected with the mother's mental illness. In considering the effects of a mother's mental illness

upon the family as reflected directly in agency contacts it would seem more logical to confine ourselves to hospitals and children's agencies. These two types of agencies are objective indices of the breakup of a family by mental illness and show that the patients and the children have needed the services of social agencies. These agencies would be called in only as a last resort when the mother could no longer function in her role of homemaker. The contacts with agencies whose whole emphasis is upon children: Division of Child Guardianship, The Society for the Prevention of Cruelty to Children, Child Welfare, Children's Mission, Children's Aid Association, Homes and Nurseries, numbered 101. This is a large number of contacts. When one recalls that there were 358 agency contacts with mental hospitals included and 279 with mental hospitals excluded, the number 101 assumes a larger importance. With mental hospitals included the 101 contacts represent 28 per cent; excluded, 36 per cent. The mental hospitals represent 8 per cent of the entire number of contacts. It seems logical to conclude that the mother's mental disorder, as seen from this survey of mental hospitals and children's agencies' contacts, had a disorganizing effect upon the family unit by removal of the mother herself and the children--at least the younger children of the family. The effect of a mother's mental illness as seen from the chapter on agencies, especially children's agencies and mental hospitals, shows the breakup of the family unit.

Social Service Department

The hospital social service department is aware of the disturbing effect of a mother's illness upon the family unit but usually arrives too late to make any provisions for various members of the family unit. Provisions generally have been made for the children and the mother hospitalized before the hospital social service department is even aware of the patient. The accent of its services is upon the patient and her tie with the community. The bulk of its services--forty-three--were home supervision visits to patients. It offered services for children namelyof advice and co-operation with children's agencies concerning maintenance of placements of children or concerning the return of the children to the family. The writer concluded that the hospital social service department could do little to avoid the breakup of the family unit. The family welfare society might avoid the breakup of the family unit if called on sometime prior to the mother's hospitalization.

Economic Status

The low economic status of so many patients--93 per cent--seems to be a contributing factor in the breakup of the family unit. In a family economically free, it is reasonable to assume, there would be less need to contact children's agencies. In a family economically free a housekeeper, a nurse, or some other person would be employed to look after the children right in the home. But many of these families contacted both

relief and children's agencies and were upset by the effect of the mother's mental illness.

Age of Patient

According to our statistics 89 per cent of the patients were fifty years of age and under. These were the ages on last admission to the Metropolitan State Hospital. (Some patients had more than one admission to this hospital). Today with a longer life expectancy span the age of fifty, the maximum for 89 per cent of the group, is not considered old. More and more really aged patients of seventy to eighty are being noted in the mental hospitals. Several studies are being conducted by hospital physicians to learn why. Interest in old people is increasing and geriatrics is now becoming as recognized a field as pediatrics. Almost 90 per cent of the patients studied can reasonably expect ten to fifteen more years of life. This means that this group of patients has more years to influence the family unit. That patients can live a long time is attested by our figures on length of hospital stays. Some patients have been hospitalized for 10, 15, 20, 30, and 40 years.

Discontinuity of Stay

One of the most disturbing aspects of mental illness comes when the patient returns to her home and fails to adjust, disrupts the family unit and needs to be rehospitalized. In the cases of long continuous hospitalization, unbroken by home visits, there was less family disruption. The patient who shuttles back and forth between home and hospital, is very dis-

turbing and a disorganizing factor upon the family unit. In some instances when a mother makes a temporary return home additional children are born and additional agency help is necessitated to care for the children.

The "Improved" Patient

The term "improved" is analagous to the term "arrested" used in tuberculosis. Such patients might recover and they might not, they are not cured. Social service workers on home supervision visits observe patients carefully for signs of recurrent illness. Such patients are potential sources of family disruption and probably a strain upon their families. Such patients often return home and demand that their children come back. Often the children return and the family is united. Sometimes it works out and sometimes it does not. In the main "improved" patients constitute a potential for another breakup of the family and the rescattering of the children.

Ages of the Children and what Happened to Them

One-hundred-thirty-nine were sixteen and under, sixty-one five years and under, twenty-seven one year and under at the mother's first onset of mental illness and hospitalization. Sixty-one children five years and under is a large number of very young children. Neglect of such young children is bound to come to the attention of the community and probably explains why our sample included thirty-five contacts with The Society for the Prevention of Cruelty to Children. Neglect of the children led frequently to the hospitalization of the

mothers and the taking of the children into custody of children's agencies. The younger the child the more evident is the effect of the mother's mental disorder because it is manifested in neglect hard to conceal. The older children--seventy-nine of them--stay on in the broken home with the father. The effect of the mother's disorder upon them is less evident although they may have to assume responsibilities of the household and be deprived of a mother's care sooner than customary.

As shown above what happens to the children when the mother becomes mentally ill and has to be hospitalized is pretty much dependent upon the ages of the children. The younger the child the more certain--in homes where the economic status is very low, true for 93 per cent of these cases--it is to be taken away from older siblings and the father. Twenty-seven were one year and under at the time of onset, sixty-one were five years and under, 139 were sixteen years and under. These are significant ages when thought of in terms of psycho-sexual development. To have a good chance at a normal psycho-sexual development it is necessary to have on hand for the first sixteen years of life both parents. For one-hundred-thirty-nine children studied here this was not possible. Their mothers' hospitalization meant removal of one parent and a break in the psycho-sexual development of these children. In the cases of these children where the mother is removed usually under traumatic circumstances e.g. calling in the police after she has become unmanageable--what is the effect? This is not an ordi-

nary broken home such as caused by death of a parent. With this kind of family breakup is associated, stigma, uncertainty, repeated traumatic breaks. The children may be shunted about in institutions, foster homes and go through periods of neglect. This is a type of broken home that needs more attention because beclouded by stigma and shame of families it has been overlooked. It is hoped that one value of this study will be to bring to attention the disorganizing influence of mental illness upon the family. A second value hoped for in this study is the recognition of the studying of the broken home in a broader way than that of desertion of a parent.

Now in the light of our conclusions let us consider our hypotheses.

a. that the effect of a mother's mental illness upon the unit is a broken home.

The study confirms this hypothesis, we believe.

b. that the youngest children are taken by agencies; older children live on in the broken home.

This hypothesis is also confirmed by this study.

c. that a possible influence of the psychotic patient is that she may get all the attention to the detriment of the other members of the family.

d. that the rights of normal children are being sacrificed for psychotic mothers.

These two hypotheses being somewhat similar might well be considered together. It is assumed that the children are normal in this study. It has been found that homes are broken by the removal of the mother and by the removal of at least

the younger children. With removal of the mother and some of the children all the children are deprived of a chance at normal psycho-sexual development. This would indicate that the children are deprived of normal rights of upbringing because the mother is psychotic and hospitalized. When the psychotic mother is one of those who shuttles back and forth between home and hospital she perforce gets the attention of all the family and the children are likely to be overlooked. No agency has as its specific purpose work with the children of psychotics but there is a specific agency for psychotics themselves e.g. the hospital social service department in a mental hospital. In other words psychotics because of the nature of their illness receive attention but the children receive no special attention because they are the children of psychotics. It seems to the writer that psychiatrically trained workers should give more specialized attention to children of psychotic mothers.

e. that the hospital social worker should take some stand or line of action when she is convinced of danger for children to live in such homes as she sometimes finds.

It was learned that by the time the hospital social worker came into the picture the children were pretty much disposed of. Her role is more to co-operate with children's agencies in keeping the children wherever they might be and to advise the patients against their premature return into the home. The hospital worker is guided in her advice and decision not primarily by the needs of the children but primarily because of possible reaction of the not quite recovered patient whom it

is her duty to supervise for the year or more deemed necessary for final discharge. It seems to be more the role of children's agencies to take some line of action in homes where conditions are harmful for children; even when mental illness is involved.

f. that the economic status of the family is a contributing factor to the broken home.

With 93 per cent classified as marginal and dependent and with twenty-three different relief agencies contacted by sixty-one patients and their families the study seems to bear out this hypothesis.

All the above conclusions are limited to this small study and must be applied to other studies with caution. The sample used represented seventy-two patients who were discharged from the Metropolitan State Hospital during the years 1930-1942. During those years, depression years, the hospital was not an admitting hospital and as a rule took on transfer from other mental hospitals long-time continued treatment cases. Long-time cases were more likely to be in the marginal group economically. The seventy-two patients represent roughly 2 per cent in the total hospital population of three thousand.

This study has been suggestive of many new phases for further study of the disorganizing effect of mental illness on the family. The following are some topics for study:

(1) Pre-hospitalization Influence of Psychotics in the Home
(2) Study of Stable Representatives in Homes with Mental Illness
(3) Study of Children's Agencies' Work with Children of Psychotics

(4) Role of Psychiatric Workers in work with Children of Psychotics.

Approved,

Richard K. Conant

Dean

A STUDY OF THE EFFECT OF A MOTHER'S MENTAL ILLNESS UPON THE FAMILY UNIT AS SEEN FROM A STUDY OF A GROUP OF PSYCHOTIC MOTHERS WHO WERE PATIENTS IN THE METROPOLITAN STATE HOSPITAL.

I Data on Patient

1. Case No._____
2. Date of Admission_____
3. Duration of stays in mental hospitals_____
4. Last determined Diagnosis_____
   a. Condition on release_____
5. Economic Status_____
6. Color_____
7. Religion_____
8. Nationality_____
9. Marital Status (Check one)
   Married_____
   Separated_____
   Widowed_____
   Divorced_____
   Unmarried_____

II Data on Family Standards

10. In Home Patient_____
    (Check) Husband_____
    Children_____
    Others_____
11. City_____
12. Family Standards
    a. Relations within family_____
    b. Delinquency records of parents or siblings_____
    c. Other abnormalities e.g. intoxication, disease_____
13. Home Conditions
    a. Character of neighborhood_____
    b. Type of neighbors_____
    c. Type of house_____
    d. No. of rooms_____
    e. Equipment_____
    f. Care given to house_____

III

14. Family--especially children

Date of Record

Family	Age	Sex M F	Occupation	Education	Disposition, plans, whereabouts, etc.
Fa.					
Mo.					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

IV

15. Social Service Dept. Services

a. Location of relatives

b. Home Supervision of patient

c. Special Services to patient

d. Services for children e.g. referral to care of a children's agency

e. S.S.I.

SUMMARY OF CASE NO._____

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